UAP OLDMUTUAL

OUT-PATIENT CLAIM FORM

Practitioners Name Dr. FirstName3 SecondName3

Practitioner's Official Stamp

Postal Address Kigali, Rwanda

Tel No. 258731332456 Mobile 2587352393332

Email rwandatestuser434@test.smart

PATIENT'S PARTICULARS

Full Name of Patient PFirstName3 PSecondName3 Date of Birth 03/11/1920

Full Name of Member (if patient is a dependant) Specimen2 Sample2

Member's Tel No. 0720000003 Member No. 100003

Member's Employer Name Sample3 Company (K) Ltd Dept. /Branch Department3 Sample3

Have you suffered from this sickness in the past? YES NO

If YES, when did it start and how frequent is it? N/A

CONSULTATION/REFERRALS DIAGNOSIS:

TREATMENT PRESCRIBED

MEDICINES:	Prescription		Injection given		Dispensed		None	
RADIOLOGY:	X-Ray		MRI/Cat Scan		Other		Other	
PATHOLOGY:	Haematology		Microbiology		Biochemistry		Histology	

Hospital Name: Consultant Referred To: Specialty:

MEDICATION PRESCRIBED:

Sample 1, Sample 11

Dr's Signature TTTTT **Date** 02/10/2023

DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature YYYYYY **Date** 01/01/2023

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